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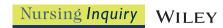
The constitution of space in intensive care: Power, knowledge and the othering of people experiencing mental illness

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Abstract

A sociological conceptualisation of space moves beyond the material to the relational, to consider space as a social process. This paper draws on research that explored the reproduction of legitimated knowledge and power structures in intensive care units during encounters, between patients, who were experiencing mental illness, and their nurses. Semi-structured telephone interviews with 17 intensive care nurses from eight Australian intensive care units were conducted in 2017. Data were analysed through iterative cycling between participants' responses, the literature and the theoretical framework. The material and relational aspects of space in this context constitute a dynamic process that is concerned with the reproduction of everyday life, the preservation of the biomedical authority of intensive care, and the social othering of people experiencing mental illness. The work of theorists such as Löw, Harvey and Foucault underpins the exploration of space as a multi-dimensional, malleable social process that both produces and is the product of social interaction and the social world. In this paper, we argue that the performative work of knowledge and power production and reproduction, considered here in relation to intensive care spaces, enables ongoing othering and disenfranchisement of people experiencing mental illness.

KEYWORDS
consumer, intensive care, mental health, othering, power, space

1 | INTRODUCTION

Evolving as a medical and nursing specialty from the mid-20th century onwards, intensive care developed with the objective of grouping together particularly unwell patients for more effective surveillance (Urden, Stacy, & Lough, 2010). As technological development rapidly advanced throughout the 20th century and into the millennium, highly specialised scientific equipment became increasingly available for the treatment of the sickest patients. The technological imperative enabled the development of specialised nursing practice dedicated to the scientific and technological management of critically ill patients.

Intensive care units dedicated to the care of the critically ill appeared in all wealthy democratic nations, and medical staff were embedded in these units from the outset (Aitken, Marshall, & Chaboyer, 2015). This historical context established a legacy still discernible today; intensive care units are a domain of biomedical authority and organised around the interests of medicine, the business of physiological rescue and scientific advancement and success. It is hardly surprising given their purpose and what we know about biomedical dominance that these are priorities in this social context (Wong, Liamputtong, Koch, & Rawson, 2015). However, these concerns challenge and displace compassionate, family-centred care throughout intensive care nursing practice. Our work suggests that these circumstances particularly apply to people experiencing mental health issues. These are seen not to 'belong' in the intensive care space and are not routinely offered holistic, compassionate and advanced care. This contradiction undermines

public expectations of nursing and nursing care as holistic and person-centred.

This paper is based on research concerned with a critical analysis of the reproduction of knowledge, power and stigma in relation to people with diagnoses of mental illness in intensive care settings. The researchers identified a paucity of research on the generation and maintenance of commonsense knowledge and everyday routines in intensive care as they intersect with the care of people experiencing mental illness. This led to an exploration of the everyday world of intensive care units. We formed two key conceptual insights as a result of the research. The first was concerned with the social reproduction of difference in the intensive care context and the positioning of patients experiencing mental illness as 'other'.[1] The second insight centred on the maintenance and legitimation of power structures that served key intensive care interests such as biomedical rescue, resistance to dangerousness and preservation of authority. The focus of this paper is the ways in which the social process of space forms part of a relational arrangement of power and knowledge in intensive care. We argue that space is an integral ingredient that shaped encounters between patients experiencing mental illness and intensive care nurses.

2 | THE RESEARCH STUDY

2.1 | Theoretical approach

The study drew on a number of social theorists to critically explore the context of intensive care and the relationships between intensive care nurses and people experiencing mental illness. A key epistemological assumption is that much of everyday life is taken for granted and experienced as a self-evident reality (Berger & Luckmann, 1966/1991). Part of the ongoing maintenance of paramount reality requires social processes that reinforce and perpetuate existing knowledge and power structures; one of which is the social production of space. Hence, the work of paramount reality maintenance was associated with maintaining the business of intensive care through the lens of biomedical work and physiological rescue. In this process, multiple realities and ways of being in the world are both disavowed and controlled through othering and stereotyping.

The conceptualisation of space has long been subject to historical philosophical and sociological inquiry. This paper draws on work of Foucault (1991) and more recent research by Harvey (2015), Löw (2016) and Pred (2014) to arrive at a conceptualisation of space as including and extending beyond physical environments. That is, space is understood as a series of shared orbits of meaning, among social actors, that contribute to the production and reproduction of

knowledge and power networks and to the maintenance of everyday paramount reality.

The development of space is considered inherently social and symbolic and as both a product and a producer of the social world. Space is a social process; people do not interact *in* space, but they interact *with* it. In so arguing, we challenge the idea of a binary opposition between structure and agency and contend that people produce social structure and social structure produces people in a constant dialectic (Berger & Luckmann, 1966/1991; Bourdieu, 1984; Giddens, 1982; Hays, 1994). Space in this broader conceptual sense can be contemplated similarly, where space (and action in that space) are constitutive of each other (Dale & Burrell, 2008; Löw, 2016).

The above perspective challenges the concept of space as mere built environments or assemblies of external, immutable and neutral entities occupied by social actors (Löw, 2016, p. 105). Rather, space is considered a dynamic milieu, enabling the preservation of social norms, stereotypes and power structures. The above conceptualisation of space is not to obscure the function of material space. Space exists across the material and lived dimensions where material dimensions include rooms, doors and physical boundaries, and the lived dimensions are expressed through feelings of subjugation or domination over space, or a sense of security or incarceration (Harvey, 2006).

Material space is, therefore, far from a neutral backdrop to our human interactions but understood as enabling the reproduction of power and knowledge that 'mould[s] relationships, power structures and action' (Sauer, 2015, p. 243). Indeed, as Foucault (1991) argues, the preservation of knowledge and power networks relies on spatial arrangements and the social activity of ordering and placing knowledge and people produces and reproduces space and knowledge. Foucault's reasoning is that the constitution (and re-constitution) of space is a manifestation or exercise of power. The maintenance of such power and knowledge networks in this context perpetuates disenfranchisement of patients experiencing mental illness and discourages contemplation of structurally embedded oppression.

2.2 | Research methods

The theoretical argument that knowledge is constructed among social beings in dynamic contexts and the ways in which data were generated are subject to the social construction of knowledge; the researcher is an active participant in such exchange (Roulston, 2016). Participants and researchers may develop new insights into old questions, challenge and revise previously held beliefs, and, in the light of the (constructed) prompts offered by the researcher, start to form new perspectives on their everyday lifeworld (Silverman, 2017).

Although interviews have long been a part of the qualitative research landscape, the understanding of how and why they are used has evolved from an exercise in extracting 'facts and answers' from a person who is believed to have them, to an exercise in meaning-making between researcher and participant (Liamputtong, 2013). In this study, interviews were conversations used to explore the understandings, perceptions and reflections

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[1]Attributed originally to the work of De Beauvoir, (1949/1997) around gender in *The Second Sex* and Said, (1978/1995). in his exposition of the binary of 'East' and 'West' in *Orientalism*, othering represents the construction of unknown or distant populations as inferior and sub-human, with subsequent social exclusion. Pinçon-Charlot and Pinçon's (2018) work exploring the Parisian bourgeoise and urban spaces arrived at similar conclusions: the social positioning of those deemed inferior and therefore as 'other' was inextricably woven into the ways in which both the Parisian elites and the 'othered' used, experienced and occupied relational and material spaces.

of intensive care nurses in relation to people experiencing mental illness in intensive care in partnership with the researcher (Dempsey, Dowling, Larkin, & Murphy, 2016; Gorli, Kaneklin, & Scaratti, 2012; Liamputtong, 2013; Silverman, 2017). The practice of reflexivity and the nature of intersubjectivity meant that interviews took the form of joint explorations of experiences resulting in the construction of knowledge. It was not simply a drawing of 'information' from the participant but a mutual exchange that centred on the experiences of the participants as intensive care nurses.

2.3 | Participants

The participants in this study were registered nurses authorised to practice by the Australian Healthcare Practitioner Regulation Agency (AHPRA). Contemporary Australian intensive care units are staffed by nurses representing a range of career points and expertise, and consequently, the study recruited participants from early, mid-career and senior nursing groups. A potential participant's practice context needed to meet the College of Intensive Care Medicine of Australian and New Zealand (CICM) minimum standards for an intensive care unit College of Intensive Care Medicine of Australia and New Zealand (2016):

> An intensive care unit (ICU) is a specially staffed and equipped, separate and self-contained area of a hospital dedicated to the management of patients with life-threatening illnesses, injuries and complications, and monitoring of potentially life-threatening conditions. It provides special expertise and facilities for support of vital functions and uses the skills of medical, nursing and other personnel experienced in the management of these problems.
>
> College of Intensive Care Medicine of Australia and
> New Zealand (2016)

The rationale for the selection criterion was to ensure participants were part of the current Australian intensive care nursing workforce and worked frequently enough to care for patients with a diagnosis of serious mental illness who were admitted to intensive care for serious physical illness or injury.

The 17 participants in the study were recruited in 2017 from eight intensive care units in metropolitan and regional cities along the Australian eastern seaboard and were practicing in a mix of level two and three intensive care units.[2] Two participants were graduates in their first year as registered nurses and three senior nurses had practiced for over 25 years. The remaining participants had professional experience of between three and ten years. All participants

practiced in intensive care settings that were co-located in hospitals with acute inpatient mental health services.

2.4 | Recruitment and ethics

Potential participants were recruited through targeted advertising in professional nursing press including the Australian College of Nurses electronic newsletter, the Nursing and Midwifery Union circular, and the Australian College of Critical Care Nurses electronic newsletter. Nurses were invited to participate in an individual semi-structured interview of up to one hour. The interviews were on average 45 min long, voluntary, subject to written consent and took place at a time convenient to the participants. All interviews were recorded and transcribed by a professional transcription service. The completed transcripts were read by the researcher in conjunction with the recording to check for accuracy. The names of participants and their workplaces were de-identified, and during transcription, pseudonyms were applied. The interviews centred on the participants' reflections on their perspectives and experiences of caring for people experiencing mental illness in an intensive care environment. The study was reviewed by the university Human Research Ethics Committee and approval granted in January 2017.

2.5 | Data analysis

Data analysis was informed by the work of Silverman (2017) and St. Pierre (2011) and aligned with the theoretical foundations of the research. These scholars argue that the responses of participants are not 'pure data', being arbitrary, contextual and open to revision. The accounts of participants were not considered to represent the 'truth' about patients experiencing mental illness in this context. The material contributed to an assemblage of meaning using transcripts, literature and theory as subject to cultural, historical and political influences. Legitimated knowledge is not politically neutral and functions to preserve power structures and authority (Weber, 1922/1978). Inequity within power structures influences which form of knowledge prevails in a given social context and who may lay claim to authoritative knowledge.

We undertook analysis using a cyclical, iterative approach with robust reflexive grounding. A reflexive approach requires a clear acknowledgement of the researcher's positioning in the interview process and data analysis, and how their presence influences the developing narrative. Reflexivity recognises the process of knowledge construction *in* research and *as* research (Charmaz, 2008) and maintains an orientation to the participants' social context (Thorne, 2000).

3 | RESEARCHER POSITIONING

As an intensive care and mental health nurse, I (first author) needed to be explicit about my own personal journey through the research process, as well as acknowledging my role in the generation and

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[2]Australian intensive care units have three main levels of complexity. Level 1 units provide immediate resuscitation and ventilation up to 24hrs, Level 2 units are usually regional centres and can provide several days of complex multisystem life support, and Level 3 are tertiary referral (major metropolitan) units who can sustain prolonged, complex multisystem life support for indefinite periods.

analysis of data. Positioning myself in the research demanded an acknowledgement of the inherent privilege afforded to me as an experienced nurse and academic. I explored the structural disenfranchisement of patients experiencing mental illness in the intensive care unit through the perspectives of the nurses who care for them. In essence, I was studying in part, 'those disadvantaged by the same system that has advantaged me' (Vanner, 2015, p. 22). As an intensive care nurse, I am part of the system that has failed people experiencing mental illness, perpetuated labelling, and preserved the primacy of biomedical care above all else in the intensive care context.

Further, the structures that supported me to conceptualise, construct and execute a study about disenfranchised people were possible because I was afforded many of the privileges many people living with mental illness are not. In my work with intensive care nurses, our discussions of people in our services were influenced by our own assumed power and privilege about how they should be and act in the space of intensive care, a space effortlessly assumed to be for us, controlled by us and set up to meet the needs and interests of biomedical authority.

I commenced this study convinced that the broader world would reflect my own social and political positioning as both a mental health nurse and an intensive care nurse. While I found that many of my initial assumptions about othering and the preservation of power structures ultimately aligned with my evolving research, the challenge was to first to move beyond the participants' words as harbingers of 'the truth' and second to realise that data generation is construction, not revelation.

Continuously revisiting my intellectual positioning, I maintained a journal both during the phase of participant interviews and iterative analysis, and then again during the construction of analytical outcomes. As my understanding of the social construction of knowledge deepened and strengthened, so did my ability to turn this critical eye on to my own role in generating data and co-constructing knowledge.

It is crucial to recognise the role of the analytic eye in the production of space (Löw, 2016). Transcripts were read and re-read, and rather than a search for recurring words or themes, inconsistencies and contradictions were noted. The timing and placement of participant and interviewer comments were analysed to assist with the contextualising and positioning of data. Through immersion and memo writing, data were interrogated through critical questioning: the how and when of responses, and the over-arching inquiry of 'what is happening here?' (Silverman, 2017). Analysis was undertaken with continual reference to literature and theory creating a conversation between the three sources of data.

Sandelowski (1993) affirms the concept of constructed realities but further argues that participants' narratives borne out of interviews are inherently revisionist, given their temporality, and endorses the role that re-telling plays in forming new connections and understanding of experiences. This argument aligns with the widely held view that the research process will not reveal any sort of inalienable truth but will, in the course of a short, temporal interaction with a number of research participants, help to inform new, socially constructed perspectives or ways of knowing (Bailey, 1996; Guba & Lincoln, 2005).

4 | SPACE AS A SOCIAL PROCESS IN INTENSIVE CARE

A consideration of the process of othering in intensive care interrogated accounts of the relational arrangement of nurses and patients experiencing mental illness, and the ways in which encounters between nurses and patients shaped and were shaped by material and relational space. The work of Löw (2016) reinforces this point by suggesting that one of the functions of the dynamic reproduction of space is the social work of positioning people as the 'other'. Patients experiencing mental illness were interpreted as a disruption to the 'business' of intensive care, out of place, undeserving and interrupting everyday reality. In short, the social construction of intensive care spaces generated this patient group as 'spatial nuisances' (Pinçon-Charlot & Pinçon, 2018, p. 121).

4.1 | Patients experiencing mental illness entering intensive care units

Very little is formally documented about the prevalence of admissions to intensive care of those experiencing mental illness, both in Australia and globally, and research specifically addressing the presence of people experiencing mental illness in intensive care is scarce. Intensive care admissions related to a person's psychiatric diagnosis are usually the result of a physiological injury associated with self-harm or suicide attempt, such as self-poisoning or overdose, hanging or, more rarely, self-immolation (Johnson & Crilly, 2016). Data from our research participants suggest most intensive care admissions following self-poisoning last from 24 to 72 hr and culminate in an awake and ambulant patient.

While it is no longer unusual for intensive care units to house awake and ambulant patients for short periods of time, our research suggested that the presence of patients experiencing mental illness, or those with a mental illness label, evoked a different use of material space by intensive care nurses. The social and cultural stereotype of inherent dangerousness, unpredictability and violence prompted accounts of the re-positioning of intensive care spaces to protect the everyday reality of intensive care, reinforce the legitimated authority of intensive care staff, and sustain power and knowledge networks.

5 | THE ORGANISATION OF MATERIAL INTENSIVE CARE SPACES

The material spaces of intensive care units are pre-structured and designed around continuous surveillance and unimpeded access to the unwell patient.Löw (2016, p. 116) draws on Stroker (1987) to reinforce the point that 'things and people occupy historically established

places'. Reminiscent of Bentham's panopticon,[3] intensive care units are traditionally organised to ensure that all patients are observable always from a central point and normally the nurses' station (Thompson et al., 2012). There are of course exceptions, and designs have evolved as intensive care units grow in sophistication.

Australian intensive care units are tightly controlled places. Access to units is through locked doors and contains a separate entry for non-intensive care personnel such as patients' families, or healthcare staff from other areas of the hospital. Cubicles are often demarcated by a painted line on the floor, and lines are sometimes painted directly from the visitor waiting area to patient areas, to deter visitors from venturing into spaces dedicated to backstage nursing and medical work (Turnbull, Flabouris, & Iedema, 2005). Eriksson, Lindahl, and Bergbom (2010, p. 53) describe intensive care as 'dominated by a rational view' and constructed around the needs of staff and technology rather than those of patients. The authors argue that the ways in which intensive care spaces are constructed and controlled are counter-therapeutic and hostile to caring and to human connections between patients and their loved ones (Eriksson et al., 2010, p. 55).

Within Australian intensive care units, there are zones controlled by nurses where access is dependent on the status, qualifications and assumed knowledge of those seeking to go inside. Access to the medication room, for example, is generally by identifiable swipe card or similar digital identification, and highly specialised equipment is locked or quarantined and accessible by permission only (Scott & Pollock, 2008). While medical staff are generally free to access all areas and resources, visiting relatives and other healthcare staff are subjected to surveillance by nurses as they move through the patient care zones of intensive care. The nurses' station, the location of the patients 'on the floor' and the doctors in private offices and their free access to all areas, bears out the observation of Pinçon-Charlot and Pinçon (2018, p. 119) that 'social groups tend to occupy distinct places in physical space, mirroring the distances and oppositions that define them socially'. This effect is observable in the following account:

> I think safety is standard for all the patients…but of course mental health patients need double safety compared to other patients. So, we always agree that when the patient comes in, we should be ready and more safe. There are restraints in the trolley, and we try to keep the trolley away from the room. We try to see if there is anything that will hurt the patient from inside the room and take it off…and we try to see if there are enough medications in the cupboard for this patient.
>
> (Emma)

These comments reflect the routines enacted prior to the admission of a person experiencing mental illness into an intensive care unit. They are emblematic of the overall control of physical spaces, of the co-production and reproduction of knowledge and meaning, and the effect of relational aspects of space being pre-structured by 'knowledge' [the symbolic universe of medicine] over time by preceding generations of staff.

The notion of 'double safety' for patients experiencing mental illness points to the stereotype of inherent dangerousness associated with those who are users of mental health services. Such assumptions usually preceded any actual encounter with the person and, according to the study participants, frequently occurred in the absence of any sort of formal assessment process. The presumption of dangerousness prompted a number of acts which reinforced nursing ownership of the relational space yet to be occupied by the patient. Such processes reflect Cohen's (1978) argument that those who own (or are the dominant occupants of) the material space have the power to manipulate and organise activities within that space.

A participant from another ICU commented on actions associated with a patient who had been admitted following self-poisoning:

> She was one-to-one nursed, and the bedside trolley we had already taken far, far away from her bed space, and the nurse was literally sat right next to her – there's always someone watching her, like all the time – that's just in case.
>
> (Bridget)

The ways in which nurses and patients occupy and negotiate space in this context are considered in both a material sense and a lived sense (Harvey, 2015). A material sense of space is concerned with the transgression of physical boundaries. A lived sense of space is concerned with the ways in which patients and nurses use space to effect coercion or to offer resistance; knowledge and power relationships inform and contribute to the production of spaces and vice versa.

5.1 | Space and relational power in intensive care

Where nurses control material space and use containment as part of their encounters with those experiencing mental illness, they reproduce and perpetuate existing structures that position such patients as morally problematic, dangerous and in need of containment (Corrigan et al., 2002; Magliano et al., 2017; Pescosolido, Monahan, Link, Steuve, & Kikuzawa, 1999; Reavley, Jorm, & Morgan, 2016). The interplay between space and nursing actions in this context is further illuminated by the shift of the nursing role from agent of care to agent of power (Perron, Fluet, & Holmes, 2004). Such a relationship between material and historical space, and patient and nursing agency, replicates a far wider range of social circumstances between people with psychiatric diagnoses and the general population in the form of social distancing and stigmatising attitudes. It is another example of dynamics that

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[3]Jeremy Bentham's panopticon was an architectural prison structure. Foucault used the concept to illustrate power relationships realised through surveillance. The panopticon allowed guards a central point to continuously observe inmates, yet also be subjected to surveillance by each other.

pre-structure spaces. People with a psychiatric diagnosis can be openly policed and then ostracised, based on what someone like them 'might do'. A number of participants demonstrated the othering of people living with mental illness, rendering them a homogenous group, attributing possible acts of deviance to unknown others. Participants commented on the possibility of someone/anyone who is mentally ill enacting the following in intensive care: 'steal the S4s and the S8s',[4] 'frighten other people' (patients), 'use a knife or a pointed pen to hurt you' (weaponise patient care equipment), or act with indiscriminate violence.

Bridget's remarks conveyed an acknowledgement of both the visible and the invisible power structures and spaces facing patients in intensive care:

> ICU is a challenging place for them -because there's really no – it's a bit like jail for everyone I think, actually. It's our own, we run the place and it's all locked and there's a lot of rules and they all want to get out. But they have to pass everything before they can move on.

Despite such notions of power and control of space, the ways in which material space is used to manage social interactions are often ambiguous. While the control of material space is *unambiguous*, there were inconsistencies concerned with *how* actors negotiated social encounters in material and relational intensive care spaces. Susan reflected on the conflation of relationships and material planes of space. Finding herself in a closed or fixed material space, a renegotiation of relational boundaries occurs, as Susan shifts from 'nurse' to 'friend'. While this can be interpreted as a boundary transgression in opposition to professional nursing practice with a patient experiencing mental illness, there are other possibilities. In the absence of the support, skills and environment to enact therapeutic communication and empathy, it is possible that Susan's remarks described an attempt to shape the interaction as positive and compassionate rather than punitive.

> If I have a patient who is paranoid or something, I will try and be their friend. I'll try not to have that I'm superior or I'm like that authority figure. I will just try to personalize with them, and just be more their friend so that they are more trusting of me. And then if things do get hairy, then hopefully they'll see me as a person of trust rather than distrust. Otherwise it [violence] just sort of takes you by surprise and you just have to deal with what you've got in front of you.

Susan's account suggests an acknowledgement of power imbalances and the way she and the patient are positioned socially and politically in this encounter.

[4]S4 and S8 are abbreviations for scheduled medication. In Australia, this refers to controlled drugs such as opiates and benzodiazepines.

5.2 | The organisation and protection of relational and material spaces in intensive care: Social distancing

There were also inconsistencies around spatial encounters in the research context that shifted on a continuum from closely shadowing patients to creating distance. A participant reflected on the ways in which nurses socially negotiated distancing and caring when working with patients who are experiencing mental illness:

> I think that people… and I admittedly at times for myself… think that our personal judgement interferes with the quality of care that these people receive. I suppose there's a withdrawal from care, you think oh, well if I go in there, I'm going to upset them, so I will just you know, hang back as much as I can, and that's kind of fed over to handovers, through other people, the assessment of that patient….you know whether correct or not, I think that there definitely a withdrawal of care, standards of care…isn't necessarily like it would be for someone without a mental illness.
>
> (Penny)

Yet, in the negotiation and control of space there were two common manoeuvres used by intensive care nurses in their work with patients experiencing mental illness: social distancing and surveillance. The latter is discussed further presently.

> So usually, the person will just not engage with the patient at all. They sit at the desk. In our unit the bays are set up, we have an electronic system for our obs and everything so you very much can place yourself at that desk with the patient in eyesight but not be engaged at all. You know they're a mess – they haven't been up for a shower, haven't been washed or all those ADLs and things taken care of.
>
> (Carly)

Lucy reflected on distancing through the avoidance of interpersonal communication rather than physical evasions:

> We're not skilled at when these people wake up… some people will avoid speaking with that patient because they don't know what to say or what – people are scared that they might upset them and make it worse, or they'll upset themselves

A few assumptions associated with caring for people experiencing mental illness could be extrapolated from the accounts of both Lucy and Carly, such as a person could be 'set off' if the wrong thing was said, or they could commit random violence towards nurses. These assumptions suggest commonsense knowledge that those experiencing mental illness are fundamentally

different, possibly lesser humans and most certainly unlike the nurses. The withdrawal of physical care and of communication in direct opposition to professional nursing practice is interpreted as an example of othering and de-humanising of people experiencing mental illness.

The above data contributed to understanding the relationship between space, power and people. Refusing to engage with the space occupied by patients experiencing mental illness exemplified the replication of social distance: spatial relationships replicate social relationships. In contrast to intensive care patients who do not carry a label of mental illness, those who do have little agency in their positioning in the space of intensive care. Nurses, however, are able to participate in the reproduction of social distancing by electing to withdraw although bound by the structure of surveillance as an institutional norm. It is possible that such withdrawal from caring is a point of resistance by nurses who experience fear or discomfort in their encounters with patients who they see as essentially different to themselves.

5.3 | The occupation and reinforcement of relational and material space in intensive care: Surveillance

As Foucault (1991) articulated through his work on institutions and surveillance, part of the control of space within intensive care nursing involves staff engaging in the surveillance of patients when they move from their assigned room. Indeed, intensive care units are designed to optimise surveillance. The excerpt below refers to patients experiencing mental illness who wish to walk around the intensive care unit:

> A patient wants to walk around all over the ward at night time...we don't want them to do that because we see it as unsafe. And what may happen is we start following them around and kind of barricade them from leaving. So, there might be up to 3 or 4 staff members with them at that time. The doctor usually comes with us as well, so ...we're following them and usually they have a cannula and they might get Serenace or if it's really bad, Midazolam to calm them down. So we're pretty mean or harsh because if we can't convince them within the first 20 minutes or so, roughly about that time period, we kind of give up. So they're stuck with us and of course we're in a locked ward, yeah, and so we will one-to-one them or single them, depending on the staffing, and then yeah we're pretty mean.

Reference to being 'mean' and 'harsh' is reminiscent of earlier discussion on the experience of dissonance by the nurses as they move between being agents of care to agents of control (Cox, 2007). The recruitment of medical staff as authority figures may have been an act of leverage or coercion. The outcome of a patient

transgressing space and boundaries was biomedical intervention: chemical restraint through sedation, without any ostensible clinical indication such as psychomotor agitation or severe distress. However, it is possible that the act of simply walking around outside of prescribed times and spaces was interpreted as a sign of agitation. Without recourse to the therapeutic nursing skills required to work with the person experiencing mental illness, the staff turned to biomedical intervention. Following the exercise of biomedical power, control is restored. The patient is 'stuck with' their observers and agents of control, in a 'locked ward' being 'singled'[5] or nursed 'one-to-one'.

The absence of professional consideration around the free movement of patients experiencing mental illness in the intensive care space points to the priorities of intensive care, a material space designed by and for intensive care clinicians. The needs of patients who are experiencing mental illness, a commonplace patient population in intensive care, may not be met because of the arrangement and location of people in this space (Sauer, 2015). The only remaining recourse, it seems, is surveillance and reinforcement of power structures through space, both material and conceptual.

Concerns about anticipatory surveillance and restriction or restraint are represented in other health settings such as mental health care, and these practices are contentious in police and justice systems and in the far broader context of human and civil rights. Exercising physical power over patients for the benefit of institutional safety and the welfare of other patients, based on pre-interpreted assumptions about the person, is a form of Weberian (1922/2002) legitimated power, sanctioned by the institution and the legal–rational power of the nursing and medical role. Much routine surveillance appears to be based on a series of cautionary tales that have become socially objectified, reified and internalised. However, such surveillance is also grounded in a deep-seated philosophical approach to medicine and health care where the relational arrangement of bodies and space is a system of social stratification that perpetuates and sustains legitimated knowledge and power networks.

Bridget recalled involvement in the most intimate personal care activity for a patient in her care: the person had complained about having an indwelling urethral catheter and had remarked (without further action) that she wanted to remove it while using the toilet:

> ...by the time I finally got her back to the unit – because the toilets are not in the units - you have to walk to another unit to get to the toilet. After that, when I go back - the nurse, the seniors were like, okay you're not allowed to go to the toilet anymore. Like they told her that. You'll have to use a pan by the bed, in a chair, because we can't trust to take you to the toilet if you're going to give trouble to the staff member taking you there.

[5]Singling or specialling a patient refers to a practice of maintaining a continuous physical and visual vigil of a patient. The practice is not confined to mental health and is widely employed in physical care settings for any patient who is viewed as unpredictable or an absconding risk.

Sam recounted a common trope in her unit which suggests a particular archetype of patients experiencing mental illness associated with spontaneous self-harm

> I guess you've always got to have your eye on what they're doing; you can never sort of…I guess you've got to be vigilant with them. They tend to – if they were in the shower or something like that, they might try and cut themselves and do stuff like that. Whereas if you're looking after someone else…they don't do that sort of thing.

Close observation and surveillance can be easily demonised as an act of intrusion and a demonstration of authoritative power that functions as a tool of social ostracism. However, people experiencing mental distress are at risk of self-harm, harm from other patients, and deterioration in their mental and emotional state (Cleary, Jordan, Horsfall, Mazoudier, & Delaney, 1999; De Santis et al., 2015). The practice of surveillance, when combined with expertise in mental health nursing, can be reproduced as a therapeutic gaze, supporting the safety and well-being of patients and building empathetic knowledge of distress and recovery for each person (Hamilton & Manias, 2007).

However, works by Fletcher (1999) and more recently Wyder et al. (2017) found that mental health nurses were equally likely to see observation as a rejection of humanistic values viewing surveillance as an act of power and control. The scholarly community of mental health nurses continues to grapple with the ethical and therapeutic dimensions of surveillance and observation (Bowers et al., 2008; Buchanan-Barker & Barker, 2005; MacKay, Paterson, & Cassells, 2005; Maharaj, O'Brien, Gillies, & Andrew, 2013; Manna, 2010; Stevenson & Cutcliffe, 2006) which renders a consideration of the function of space a critical issue.

6 | CONCLUSION

Hospitals as material and relational spaces reproduce power relationships that dictate 'who controls access, who sets the agenda, whose interests are served, and how those lower in the socioeconomic hierarchy are treated in ways that continually remind them – and keep them – in their place' (Poland, Lehoux, Holmes, & Andrews, 2005, p. 72). Such theorising around space, and the application to an intensive care context, makes a broadly similar point to Berger and Luckmann's (1966/1991) proposal of a symbolic universe—a transcendent, immaterial space (of which the institution is a manifestation) concerned with access, agenda, serving interests and the preservation of everyday reality.

As Löw (2016, p. 116) puts it, 'Symbolism [in our case medical symbolism] provides, so to speak, the 'operating manual' for pre-structuring people's action'. Nurses occupy spaces and control patients within them as ways of reinforcing and protecting the knowledge–power relationships associated with nursing, medical

authority and institutional expertise. Such social actions conflate space, nursing identity and autonomy (Edwards, 1998; Pred, 2014). In the words of Jacob, Perron, and Corneau (2014, p. 152), institutional material space 'is as much about material division and the many ways in which they reflect and reinforce relations of power as it is about social dynamics, symbols, discourses that are embedded in daily ways of thinking and doing'.

This paper explored the dynamic relationship between space, power and knowledge production through the context of research on the presence of people experiencing mental illness in intensive care settings. In intensive care, the social production and reproduction of power and knowledge networks cannot be separated from the social reproduction of space, where social processes of intensive care include the use of surveillance and social distancing during encounters with patients. Both social acts interact and reproduce intensive care spaces, reinforce power and expertise, reflect broader community anxieties around stereotypes of difference, and contribute to the ongoing social othering of people experiencing mental illness.

The intensive care space exists beyond the mere material and is a representation of intensive care *business*, knowledge networks and power relationships. The rejection of patients experiencing mental illness through acts of coercion and suspicion is founded on a series of socially constructed stereotypes and historically embedded spatial and social arrangements that encompass material planes, atmosphere, intuition and action.

The continued, embedded disenfranchisement of people experiencing mental illness and the work of reality maintenance in intensive care are social processes and are situated within enduring power structures. The power structures that perpetuate oppression and disenfranchisement are unwittingly supported and reinforced by nurses in everyday practice, and it is political awareness of these structural inequalities that offers an opportunity to contemplate change. The significance of this work is advancing critical consciousness as integral to effecting political and social change.

An acknowledgement of the ways in which social mores are produced and reproduced by nurses as they interact with patients experiencing mental illness in intensive care spaces creates an opportunity for critical reflection on the unique and fundamental nursing role in intensive care. We argue that nurses, through critical reflection, have the capacity to work with space as a therapeutic medium, moving away from the reinforcement of power and preservation of social othering patients experiencing mental illness, to an agent of change and consciousness-raising around the care and support of vulnerable people in often frightening and hostile environments.

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